DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 7331-98
13 December 1999

[redacted]

Dear [redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 2 December 1999. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the advisory opinion furnished by the Specialty Advisor for Cardiology. dated 31 August 1999, a copy of which is attached, and the comments of your counsel.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained in the advisory opinion. It was unable to conclude that you were more than minimally impaired by any medical condition at the time of your discharge, or that you would not have been fit to continue to perform your duties had you not been discharged because of your obesity. In view of the foregoing, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

31 AUG 1999

From: CAPT K.F. Strosahl, MC, USN; Specialty Advisor for Cardiology
To: Chairman, Board for Correction of Naval Records

Subj: REQUEST FOR COMMENTS AND RECOMMENDATIONS IN THE CASE OF FORMER [redacted]

Encl: (1) BCNR File
(2) Service Record / Medical Record / Dental Record
(3) VA Record / Medical Record

1. Enclosures were received 27 AUG 99 and reviewed.

2. Findings of fact:

a. The member enlisted in the United States Navy with a 3/3/69 AFEES SF 88 documented BP of 130/80. Subsequent SF 88 entries show BP of 116/80 on 12/5/72, 124/80 on 12/11/76, and 126/80 on 11/8/82. He had a BP of 138/98 during an Emergency Room visit on 10/24/82 and a BP of 118/74 at an episode of care on 2/16/83. SF 558 of 4/9/83 documents a BP of 200/130 and the diagnosis of Viral Syndrome and HTN were entered. No treatment for HTN is documented. On 12/29/83 he was treated for epistaxis in an EMD with a BP documented of 166/112 without BP treatment. A follow-up BP on 12/30/83 was 170/118.

b. On 3/3/84 the member was evaluated for "blackout spells" in an EMD at Mayport and the BP was 160/124. Anti-hypertensive therapy was begun with propranolol 40 mg BID and hydrochlorthiazide (HCTZ) 50 mg daily. Follow-up on 3/26/84 revealed a BP of 140/102 and the SF 600 documents normal Fundi and alcohol abuse at a 6 pack per day (along with tobacco abuse of 1 ½ ppd). Follow-up on 11/15/84 reveals a BP of 170/110 with the fundi noted as negative and the EKG as showing left ventricular hypertrophy (LVH).

c. The member was seen by Internal Medicine, LCDR Robert Johnson, on 11/21/84 with a BP of 146/100, "Fundi mild AV nicking without Hemorrhages or Exudates", an S4 gallop, and a mid-epigastric systolic bruit. Renovascular hypertension was considered as well as pheochromocytoma and appropriate studies were ordered. The BUN was 12, Creat 1.4, Total Cholesterol 136, Urinalysis without protein, casts or red cells. A hypertensive excretory urogram was reported on 12/17/84 as normal. The result of urine metanephrines, catecholamines, total protein and creatinine are not found in the record but the entry of 5/31/85 indicates that "work up for secondary hypertension essentially WNL". A six month limited duty board was dictated 1/16/85 and the member was found fit for duty by the health record entry of 5/31/85 at which time the BP was 138/86 on propranolol 40mg BID, prazosin 5 mg TID and HCTZ 50mg BID. The member was retired on 6/7/85.

d. Following the member's separation from the military, he abused alcohol and drugs, including shooting up cocaine on 25 JAN 97 resulting in cellulitis, abscess

and myonecrosis of the left arm leading to hospitalization 1/30 through 2/19 97. He subsequently received inpatient substance abuse treatment at the Coatesville VAMC in OCT 1987. He was hospitalized 4/17-30/92 for Major Recurrent Depression and Acute Post Traumatic Stress after witnessing a friend's death by being run over by a tractor trailer (non-military traumatic stress). He was hospitalized 5/25-7/10/95 for Adjustment Disorder with Depressed Mood and history of Alcohol Abuse in remission and Cocaine Abuse in remission. He suffered a back injury in a fall 2/10/97 resulting in a CT scan 2/13/97 showing bulging discs at L3/4 and L4/5 and underwent emergency L3-4-5 laminectomy and 4-5 diskectomy. This resulted in a cauda equina syndrome with paraplegia and neurogenic bladder and bowel dysfunction (non-military injury).

e. The military health record contains no evidence or reference to an acute myocardial infarction in APR 1984 that was subsequently recorded at VA entries based upon the patients reported history. In fact, the VAMC findings of 7/21/98 clearly document the absence of coronary artery disease. The member had a normal thallium exercise stress in 1995. He a normal cardiac catheterization 7/3/96, an Persantin thallium stress test 4/15/98 reports "a small, discrete, proximal infero-septal wall defect suspicious for scar" that is a common finding in hypertensive patients without coronary disease. Another cardiac catheterization 5/5/98 revealed minimal coronary artery irregularities with normal wall motion and systolic function.

f. The member was admitted to a VAMC 3/27-4/4/91 for Acute Chest Pain Secondary to Discontinuation of Clonidine with Elevated CK of Undetermined Etiology. The serial CK determinations revealed a peak CK of 340 with 8 units of CKMB (2.3%) which is negative for cardiac injury.

3. OPINION: Upon review of the record I find no evidence that the member should have been referred to the CPEB in MAY of 1985 and that the fit for duty determination was appropriate and correct. It is likely that the blackout spells in 1983 were due to alcohol abuse with resultant hypertension. The difficulty in controlling the BP is evidenced by his failure to follow-up as directed in 1983. The issue of non-compliance with medication is common in alcoholics and is evidenced by the 1991 admission for self-discontinuation of clonidine and the resultant rebound phenomenon. The member's claim #07747-96, DD Form 149, that he had a "heart attack in Navy in 1984" is unfounded. The member's claim that his "heart condition started in the U.S. Navy" is partly correct. The cardiac enlargement is caused by uncontrolled hypertension. In patients who are compliant with medical therapy and achieve long term BP control, this can be avoided or reversed. The member must take some responsibility for his health by complying with the medical treatment and follow-up. Cocaine abuse is directly related to hypertension and to myocardial damage. The self-abuse is the proximate cause for his enlarged heart even if the hypertension was first diagnosed while on active duty.

Very Respectfully,

K.F. STROSAHL